Surgical Modifiers

Introduction

Purpose

The purpose of this module is to provide participants with an understanding of the policies and procedures of surgical modifiers for professional services. This module includes detailed information about correct billing practices and Medi-Cal reimbursement policy.

Module Objectives

- Explain the use of modifiers in the Medi-Cal program
- Demonstrate the correct placement of modifiers on the claim forms
- Identify modifiers used by a surgical team member
- Review pre-operative and post-operative services policy
- Identify modifiers for Non-Physician Medical Practitioners (NMPs)
- Discuss the discontinuation of local modifier ZS
- Provide general information regarding anesthesia-related drug and supply modifiers
- Explain “By Report” documentation

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (*www.medi-cal.ca.gov/mcss*).

References

The following reference materials provide Medi-Cal billing and policy information.

Provider Manual References

Part 2

Anesthesia (anest)
CMS-1500 Special Billing Instructions (cms spec)
Modifiers: Approved List (modif app)
Modifiers Used With Procedure Codes (modif used)
Non-Physician Medical Practitioners (NMP) (non ph)
Radiology (radi)
Radiology: Diagnostic (radi dia)
Supplies and Drugs (supp drug)
Surgery (surg)
Surgery Billing Examples: CMS 1500 (surg bil cms)
Surgery Billing Examples: UB-04 (surg bil ub)
Surgery: Billing with Modifiers (surg bil mod)
UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)
UB-04 Special Billing Instructions for Outpatient Services (ub spec op)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

NOTES

Description

The use of modifiers is an important part of billing for health care services. Modifiers give additional information for claims processing. The following modifiers are discussed in this training module:

- Conventional Surgical Modifiers: AG, 50, 51, 80 and 99
- Additional Surgical Modifiers:

Anesthesia Drugs & Supplies: UA, UB
Evaluation and Management: 24, 25
General Use: 22, 26, 52, 54, 55, 62, 66, 78, 79, 99
Non-physician Medical Practitioner: U7, SA, SB
Radiology: 26, TC

Use of a modifier with a CPT-4 or HCPCS code does not ensure reimbursement. Documentation of medical necessity may also be required for certain procedure codes.

Surgical Modifier Policies

Refer to the *Modifiers: Approved List* section (modif app) in the Part 2 provider manual for a complete list of approved modifier codes for billing Medi-Cal. Modifiers not listed in the *Modifiers: Approved List* section are unacceptable for billing Medi-Cal.

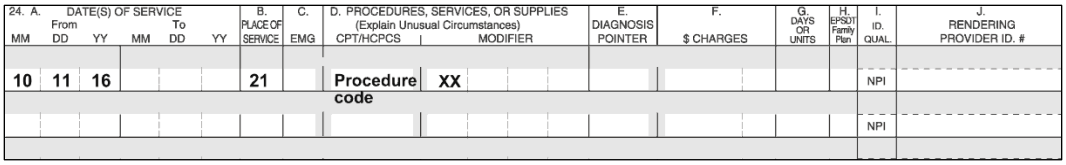
Surgical Procedures Codes and Modifiers

Inappropriate Modifier Use

The inappropriate use of a modifier, or using a modifier when it is not necessary, will result in a denial or delay in payment. All modifiers (and procedure codes) must be appropriate for the diagnosis code listed.

Claim Form Placement

Modifier form locations appear as “XX.” See claim form examples below:



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
10	11	16				21		Procedure code	XX					NPI	
														NPI	

Sample: Partial *CMS-1500* Claim Form

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
	DESCRIPTION	Procedure Code XX	101116		

Sample: Partial *UB-04* Claim Form

Billing Modifiers for Surgical Procedures

Primary Surgeon Modifiers

Codes

Modifier	Description
AG	Primary Surgeon
	Multiple Primary Surgeons
50	Bilateral Procedure
51	Multiple Procedures
99	Multiple Modifiers

Modifier Description

Primary Surgeon (Modifier AG)

The primary surgeon or podiatrist is required to use modifier AG on the only, or the highest valued, procedure code being billed for the date of service.

NOTE

Modifier AG exception: CPT-4 code 58565 (hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) must not be billed with modifier AG. Claims submitted with code 58565 and modifier AG will be returned to the provider. See the *Sterilization* (ster) section in the appropriate Part 2 provider manual for details.

Multiple Primary Surgeons (Modifier AG)

Two or more surgeons may use modifier AG for the same patient on the same date of service, if the procedures are performed independently and in a different anatomical area or compartment. All claims must include:

- Medical justification
- Operative reports by all surgeons involved
- Clearly indicated start and stop times for each procedure

Multiple Surgical Procedure Exceptions

The following medical policies have been established for specific, multiple surgeries and are not reimbursable when billed for a recipient, by the same provider, for the same date of service.

- Tubal ligations performed at the time of a cesarean section or other intra-abdominal surgery are reimbursable only when billed with CPT-4 code 58611. For more information, refer to the *Hysterectomy* (hyst) and *Sterilization* (ster) sections in the appropriate Part 2 manuals.
- A salpingectomy or oophorectomy (CPT-4 codes 58700, 58720, 58900 – 58943) billed on the same date of service as a hysterectomy (CPT-4 codes 58150 – 58285) is not separately reimbursable.
- A vaginal delivery (CPT-4 codes 59400, 59409, 59610 or 59612) billed on the same date of service as a cesarean section (CPT-4 codes 59510, 59514, 59618 or 59620) is not reimbursable unless the claim indicates a multiple pregnancy – one child delivered vaginally, and one by cesarean section.
- Intra-ocular lens with cataract surgery policy is located in the *Surgery: Eye and Ocular Adnexa* (surg eye) section of the appropriate Part 2 provider manual.
- Insertion of bladder catheter (CPT-4 codes 51701 and 51702) is not separately reimbursable when billed with CPT-4 codes 10021 – 69979.
- CPT-4 code 36000 (introduction of needle or intracatheter, vein) is not reimbursable when billed by same provider for the same recipient on the same date of service with any CPT-4 code within the ranges of 0100 – 69999 and 96360 – 96549.

National Correct Coding Initiative (NCCI)

A number of surgical procedures are subject to NCCI edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require the addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the *Surgery: Billing with Modifiers* section of the Part 2 provider manual (surg bill mod, page 5).

Bilateral Procedures (Modifier 50)

Modifier 50 is used when bilateral procedures performed add significant time or complexity to patient care at a single operative session.

NOTE

Check CPT-4 code for procedure descriptor.

Claim Form Examples Using Modifier 50

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINE 1: BUNIONECTOMY, RT FOOT. LINE 2: BUNIONECTOMY, LT FOOT.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	11	16				21		28290	AG		16171	1		NPI	
2	10	11	16				21		28290	50		16171	1		NPI	
3															NPI	
4															NPI	

OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1		BUNIONECTOMY, RT FOOT	28290AG	101116	1	16171			1
2		BUNIONECTOMY, LF FOOT	2829050	101116	1	16171			2
3									3
4									4
5									5
6									6
7									7

Sample: Partial *UB-04* Claim Form

66 DX D1D1D1D
0

69 ADMIT DX. 70 PATIENT REASON DX. 71 PPS CODE 72 ECI 73

74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE

80 REMARKS
LINE 1: BUNIONECTOMY, RT FOOT
LINE 2: BUNIONECTOMY, LT FOOT

81CC a. b. c. d.

76 ATTENDING NPI 1234567890 QUAL LAST FIRST
77 OPERATING NPI 2345678901 QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST

68

UB-04 CMS-1450
© 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: Partial *UB-04* Claim Form*: Remarks* field (Box 80)

Multiple Bilateral Procedures

When billing for multiple bilateral procedures performed by the same physician at the same operative session, providers must use modifiers AG, 50, 51 and 99.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINES 4 AND 6: MODIFIERS 50 + 51. SEE ATTACHMENT.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. D2D2D2D C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	10	11	16				21		68720	AG		16171	1		NPI	
2	10	11	16				21		68720	50		16171	1		NPI	
3	10	11	16				21		31200	51		12128	1		NPI	
4	10	11	16				21		31200	99		12128	1		NPI	
5	10	11	16				21		30130	51		10000	1		NPI	
6	10	11	16				21		30130	99		10000	1		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		DACRYOCYSTORHINOSTOMY	68720AG	101116	1	16171		
2		DACRYOCYSTORHINOSTOMY	6872050	101116	1	16171		
3		ETHMOIDECTOMY	3120051	101116	1	12128		
4		ETHMOIDECTOMY	3120099	101116	1	12128		
5		EXCISION TURBUNATE	3012051	101116	1	10000		
6		EXCISION TURBUNATE	3013099	101116	1	10000		
7								

Sample: Partial *UB-04* Claim Form

66 DX: D1D1D1D D2D2D2D
0
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
76 ATTENDING NPI 1234567890 QUAL LAST FIRST
77 OPERATING NPI 2345678901 QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
LINES 4 AND 6: MODIFIER 99=50+51. SEE ATTACHMENT.
81CC a. b. c. d.
UB-04 CMS-1450 © 2005 NUBC
OMB APPROVAL PENDING
NUBC National Uniform Billing Committee LIC9213257
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: Partial *UB-04* Claim Form: *Remarks* field (Box 80)

Multiple Procedures (Modifier 51)

The multiple procedures modifier identifies the secondary, additional or lesser procedures for multiple procedures that are performed on the same day or at the same operative session.

Reimbursement Rule:

CPT-4 Code/Modifier	Reimbursement Formula
41150 AG	100% of full-fee rate
38720 51	50% of full-fee rate
15120 51	50% of full-fee rate
31600 51	50% of full-fee rate

Billing Tip: Certain procedures billed by the primary surgeon with modifier 51 are exempt from the multiple procedure reduction rule and are paid at 100 percent of the Medi-Cal Maximum Allowable. For a list of exempt procedures refer to the *Surgery: Billing with Modifiers* (surg bil mod) section in the Part 2 provider manual.

Modifier 51 Versus Modifier 99

- Modifier 51 describes second, third or subsequent differing procedures.
- Modifier 99 describes third and subsequent identical procedures.

Assistant Surgeon Modifiers

Codes

Modifier	Description
80	Assistant Surgeon
99	Multiple Modifiers

Modifier Descriptions

Assistant Surgeon (Modifier 80)

Assistant surgeons must use modifier 80 as a part of each procedure billed. The major surgical procedure is identified by the use of modifier 80 (assistant surgeon) and any multiple surgical procedures must be identified by the use of modifier 99 (multiple modifiers).

NOTE

Not all surgical procedures reimburse for an assistant surgeon. To determine if there are any restrictions refer to the *TAR and Non-Benefit: Introduction to List* section (tar and non) in the appropriate Part 2 provider manual to verify.

Multiple Modifiers (Modifier 99)

Under certain circumstances two or more modifiers may be necessary to completely define a service.

- Use modifier 99 with the appropriate procedure code.
- Explain modifier 99 in the *Remarks* field (Box 80) for *UB-04* claims and *Additional Claim Information* field (Box 19) for *CMS-1500* claims.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
LINE 2 AND 3: 99=80+51

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. **0**
A. **D1D1D1D** B. **D2D2D2D** C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	11	16				21		XXXXX	80		129000	6		NPI	
2	02	11	16				21		XXXXX	99					NPI	
3	02	11	16				21		XXXXX	99					NPI	
4															NPI	

J. OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1		DESCRIPTION	XXXXX80	021116	1			
2		DESCRIPTION	XXXXX99	021116	1			
3		DESCRIPTION	XXXXX99	021116	1			
4								
5								
6								
7								

Sample: Partial *UB-04* Claim Form

66 DX: **D1D1D1D** **D2D2D2D** 68
0
69 ADMIT DX 70 PATIENT REASON DX 71 PPS CODE 72 ECI 73
74 PRINCIPAL PROCEDURE CODE DATE a. OTHER PROCEDURE CODE DATE b. OTHER PROCEDURE CODE DATE 75
c. OTHER PROCEDURE CODE DATE d. OTHER PROCEDURE CODE DATE e. OTHER PROCEDURE CODE DATE
80 REMARKS **LINES 2 AND 3: 99=80+51.**
81CC a b c d
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Sample: Partial *UB-04* Claim Form

Add-On Codes

Codes with “each additional” in the descriptor should not be billed with modifier 99 when performed on the same day or at the same operative session as another surgery. If billing multiple codes that have “each additional” in the descriptor use the *Days or Units* field (Box 24G) on the *CMS-1500* claim form or *Serv. Units* field (Box 46) on the *UB-04* claim form.

CMS-1500 Form

Current Billing Method

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	11	16				21		15002	AG		42500	1		NPI	
2	02	11	16				21		15003	51		20000	1		NPI	
3	02	11	16				21		15003	51		20000	1		NPI	
4	02	11	16				21		15003	51		20000	1		NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Preferred Billing Method

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	11	16				21		15002	AG		42500	1		NPI	
2	02	11	16				21		15003	51		60000	3		NPI	
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

UB-04 Form

Current Billing Method

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1			15002AG	021116	1	42500
2			1500351	021116	1	20000
3			1500351	021116	1	20000
4			1500351	021116	1	20000

Preferred Billing Method

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1			15002AG	021116	1	42500
2			1500351	021116	3	60000
3						
4						

Other Surgical Modifiers

If modifiers U7, 22, 62, 66, 78, 79 or 80 are used for multiple surgical procedures billed by someone other than the primary surgeon (AG), then use modifier 99 with the appropriate procedure code. Explain modifier 99 in the *Remarks* field (Box 80) on *UB-04* claims and *Additional Claim Information* field (Box 19) on *CMS-1500* claims.

NOTE
When billing for a primary surgeon with modifier AG, use modifier 51 for second, third or subsequent differing procedures. Use modifier 99 for third or subsequent identical procedures.

Complex Operative Procedure Modifiers

Codes

Modifier	Description
22	Increased Procedural Services

Modifier Descriptions

Increased Procedural Services (Modifier 22)

Describes procedures involving significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects of:

- Prior surgery
- Distorted anatomy
- Irradiation
- Marked scarring
- Adhesions
- Infections
- Very low weight
- Inflammation

When the service provided is greater than usually required for the listed procedure, requiring the use of modifiers 22 and AG, use modifier 99 with an explanation in the *Remarks* field (Box 80) on *UB-04* claims and *Additional Claim Information* field (Box 19) on *CMS-1500* claims. Indicate that the procedure performed required the use of both modifiers (99 = AG + 22). Justification is required on the claim.

NOTES

Additional Surgeon(s) Modifiers

Codes

Modifier	Description
62	Two Surgeons
66	Surgical Team

Modifier Descriptions

Two Surgeons (Modifier 62)

Identifies a surgical procedure that requires two surgeons who are performing distinct parts of a procedure.

NOTE

Each surgeon would bill with modifier 62.

Surgical Team (Modifier 66)

Indicates the services of all physician members of a surgical team. Anesthesiologists must submit a separate claim for services.

NOTE

CPT-4 guidelines for modifier 66 allow each member of a surgical team to bill separately for their services; however, Medi-Cal requires that all team members bill on the same claim form.

Operative/Postoperative Modifiers

Codes

Modifier	Description
52	Reduced services
54	Surgical care only
55	Postoperative Management only
58 NCCI-associated	Staged or related procedure by the same physician during the postoperative period

Modifier Descriptions

Reduced Services (Modifier 52)

For use with surgery codes: 66820, 66821, 66830, 66840, 66850, 66920, 66930, 66940 and 66982 – 66985. Requires “By Report” documentation.

Operative Postoperative Management (Modifier 54)

Surgical care only

Operative Postoperative Management (Modifier 55)

Post-operative management only

Staged or Related Procedure Postoperative Period (Modifier 58)

May be used with CPT-4 codes 15002 – 15429 and 52601 to address subsequent part(s) of a staged procedure.

Additional Operative Procedure Modifiers

Codes

Modifier	Description
78 NCCI-associated	Unplanned return to operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period
79 NCCI-associated	Unrelated procedure or service by the same physician during the postoperative period

Modifier Descriptions

Return to Operating Room (Modifier 78)

Unplanned return to the operating/procedure room by the same physician following the initial procedure during the postoperative period.

Return to Operating Room (Modifier 79)

Unrelated procedure or service by the same physician during the postoperative period

Use of Discontinued Procedure Modifiers

Codes

Modifier	Description
53	Discontinued procedure; requires “By Report” documentation
73	Discontinued procedure in an outpatient hospital/ambulatory surgery center prior to the administration of anesthesia
74	Discontinued procedure in an outpatient hospital/ambulatory surgery center after administration of anesthesia

NOTE

A number of surgical procedures are subject to NCCI edits. To process correctly, claims submitted for multiple surgical procedures on the same day may require the addition of an NCCI-associated modifier. Information about NCCI-associated modifiers is included in the *Correct Coding Initiative: National* (correct) section in the appropriate Part 2 provider manual.

Brainteasers:

1. A pregnant woman has been diagnosed with cervical dysplasia and is scheduled for a Cesarean section on February 10, 2016. The cone biopsy was performed on January 17, 2016. What modifier should be used for the cone biopsy? _____
2. An exploratory laparotomy was performed due to a gunshot wound. A few hours later the patient’s blood pressure drops, and the patient is urgently taken back to the operating room to reopen and explore for possible leakage from the surgical site. What modifier should be used for the reopen/explorative procedure? _____

Answer Key: 1) 79; 2) 78

Evaluation and Management (E&M) Modifiers

E&M Examinations

Policy for Pre-Operative Visits Before or on the Day of Surgery

When performing a pre-operative visit on the day of or the day before a surgical procedure, the same primary or assistant surgeon must document medical justification in the *Remarks* field (Box 80) of the *UB-04* claims form or the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form. Exceptions to this policy may be made when the pre-operative visit is an initial emergency visit requiring extended evaluation or detention.

Postoperative

Office visits, hospital visits and consultations related to a surgery and billed during a follow-up period of the surgery, are not separately reimbursable if billed by the surgeon or assistant surgeon.

Code Exceptions

Modifier	Description
24 NCCI-associated	Unrelated E&M service by the same physician during a postoperative period
25 NCCI-associated	Significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service

NOTE

Modifiers 24 and 25 require documentation.

NOTES

Non-Physician Medical Practitioner (NMP)

Non-Physician Medical Practitioners (NMPs) include:

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Certified Nurse Midwife (CNM)

Codes

Modifier	Description
U7	Physician assistant service
SA	Nurse practitioner rendering service in collaboration with a physician
SB	Nurse midwife

Billing Information

Reimbursement for services rendered by an NMP can only be made to the employing physician, organized outpatient clinic or hospital outpatient department. Separate reimbursement is not made for physician supervision of an NMP.

The following items need to be included on claim forms for reimbursement:

- The NMP's NPI must be noted in the *Remarks* field (Box 80) on *UB-04* claims or *Additional Claim Information* field (Box 19) on *CMS-1500* claims.
- When billing for assistant surgeon services performed by the PA, services must be billed with modifiers 80 and 99 (multiple modifiers).
  (99 = 80 + U7).

NOTE

Surgical codes that are reimbursable for NMP services can be found in the *Non-Physician Medical Practitioners* (NMP) section (non ph) of the Part 2 provider manual. Separate reimbursement is not made for physician supervision of an NMP.

NMP Services Claim Examples

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
CNM, JANE SMITH, NPI 1234567890

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. D1D1D1D B. C. D.
E. F. G. H.
I. J. K. L.

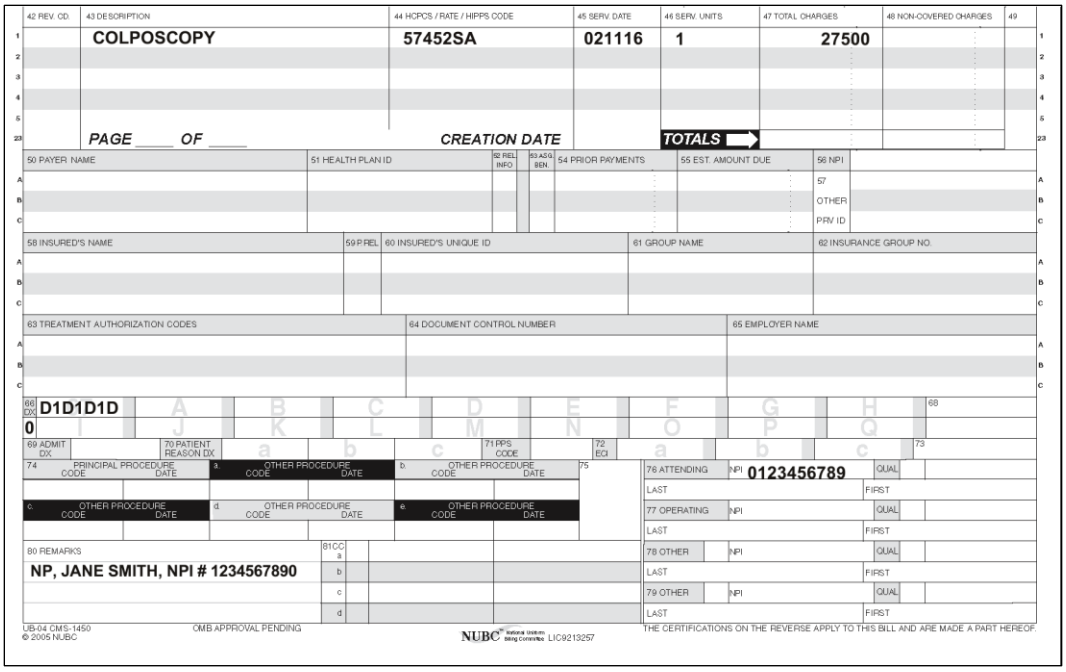
22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 02	11	16				11		57452	SB		27500	1		NPI	1098765432
2														NPI	
3														NPI	
4														NPI	

J OR SUPPLIER INFORMATION

Sample: Partial *CMS-1500* Claim Form



Sample: Partial *UB-04* Claim Form

Anesthesia Related Drugs and Supplies Modifiers

Codes

Modifier	Description
UA	Supplies and drugs used in surgical procedures with other than general anesthesia or no anesthesia
UB	Supplies and drugs used in surgical procedures with general anesthesia

Billing Reminders

- Modifiers UA and UB are mutually exclusive; therefore, only one modifier is allowed for each surgical procedure.
- Modifiers UA and UB do not conflict with the use of other required modifiers. Modifiers AG or 80 may be used on separate lines with UA or UB on the same claim form.
- Do not attach an itemized list of supplies to the claim.
- Surgical procedures with modifier UA or UB performed more than once on the same day to the same recipient by the same or different provider(s) require additional documentation.

HIPPA Code Conversion for Local Modifier ZS

On August 1, 2015, DHCS discontinued local modifier ZS (professional and technical component). When billing for both the professional and technical components, a modifier is neither required nor allowed per HIPAA compliance and CMS guidelines.

The termination of local modifier ZS affects claims and TARs for all split-billable procedures except for MRI, MRA and PET procedures. See the relevant sections of the Part 2 Medi-Cal Billing and Policy manual for details pertaining to the use of modifiers for MRI, MRA and PET procedures.

Claim Completion

Physician Billing: The physician bills for both the professional (26) and technical (TC) components and then reimburses the facility for the technical component (TC), according to their mutual agreements.

A *CMS-1500* claim form is completed with the procedure code on one claim line and without a modifier in the *Procedures, Services or Supplies/Modifier* field (Box 24D).

Facility Billing: The facility bills for both the technical (TC) and professional components (26) and then reimburses the physician for the professional component, according to their mutual agreements.

A *UB-04* claim form is completed with the procedure code on one claim line and without a modifier in the *HCPCS/Rate/HIPPS Code* field (Box 44).

Attachments – By Report

Attachment Requirements

The following is a list of Medi-Cal services that require “By Report” attachments:

- Surgical procedures
- Complicated procedures
- Unlisted services
  - No specific CPT-4 description of service
  - Requires a TAR
  - Time involved
  - Nature and purpose of procedure
  - Relation to diagnosis
- Anesthesia time

Documentation Requirements

The following is a list of required “By Report” documentation:

- Patient’s name
- Date of service
- Procedure code
- Operative report
- Estimated follow-up days
- Size, number and location of lesions (if applicable)

Learning Activities

Modifier Review

1. An assistant surgeon was involved in performing the procedure. What modifier should be used to bill for the assistant's services?
   a. 99
   b. 80
   c. U7
2. Surgical procedures that require two surgeons who perform on distinct anatomical regions on the same recipient, same date of service, may each bill with modifier AG on separate claims.
   a. True ☐
   b. False ☐
3. Procedures billed with modifier 51 are reimbursed at what percentage of the Medi-Cal maximum allowable?
   a. 50%
   b. 100%
   c. Both
4. Is it possible to bill with more than one primary surgical procedure with modifier AG on the same date of service?
   a. Yes
   b. No
5. What modifier do I use if both the professional and technical components were performed after August 1, 2015?
   a. 26
   b. ZS
   c. TC
   d. None

6 For dates of service on or after October 1, 2015, providers should use the letter "O" to document the ICD indicator?
   a. True ☐
   b. False ☐

Answer key: 1) b; 2) a; 3) c; 4) a; 5) d; 6) b